Using a Patient Identification Checklist:
How to Make This a Never Safety Event in Perioperative Services

Team Leaders: Alita Campbell MSN RN OCN, Soo Ok MSN RN CPAN,
Jarrod Esguerra BBA, David Luo MIE BSIE,
University of Texas MD Anderson Cancer Center, Houston, TX
Team Members: Ashely Ajala, Carrie Edwards, Shelita Hilton, Nora Khrone, Nicole Monroe,
Julie Nichols, Raquel Porter, Deddie Simms, Latrisa Smith, Preop Nursing Staff,
Elsy Puthenparampil DNP RN CPAN, Carmen Gonzalez MD

Background Information: Patient identification is one of the Joint Commission National Patient Safety Goals. Positive patient identification involves accuracy, verification and two-way communication. Occasionally, patient armbands did not match patient labels or paperwork, leading to incorrect patient identification. Safety Events were placed and reviewed at the executive level as high-risk safety events that achieved institutional support. Preoperatively, errors in patient identification can lead to potentially serious errors. The check-in area was able to identify workflow inconsistencies, interview techniques and equipment locations as opportunities for improvement. The focus was on patient wristbands during check in, leading to the development of a checklist and subsequent audits to measure compliance.

Objectives of Project: To maintain a trend of overall reported patient ID events, to sustain no high harm and reduce patient ID reported procedures events, as they relate to safety culture and accountability by 25% six months after training in Just Culture and accountability.

Process of Implementation: A review of current workflow and observation audits were completed prior to beginning the pilot. A Patient Identification Checklist supporting hospital policy was developed. Education to staff and 50 in-person audits were completed to observe the wristband check-in process, using an electronic audit. The checklist was laminated and posted at eye level of the Patient Service Coordinator (PSC). The wristband and label printer were relocated closer to the workstation for ease of use. The patient charts filing order was changed from OR room number to alphabetical order (by last name) to reduce chart adjustments. The level of lighting was also adjusted to improve visualization by patients and staff.

Statement of Successful Practice: The baseline data included five patient ID safety events for PACU/Preop and the implementation of the new workflow resulted in zero patient ID events after the pilot. The patient ID wristband checklist helped reduce the number of patient ID events related to wristbands but is dependent on the employee adhering to the checklist.

Implications for Advancing the Practice of Perianesthesia Nursing: Not verifying patient information is a top causal factor for patient ID overall. Reminding staff about the importance of adhering to the checklist and following best practice standards for patient identification can help ensure this becomes a Never Event in Perioperative Services.